CRIME VICTIMS' COMPENSATION PROGRAM APPLICATION

A program provided by the South Dakota Department of Social Services; providing monetary assistance to victims of violent crime.

Department of Social Services
Division of Adult Services and Aging
Crime Victims' Compensation Program
700 Governors Drive
Pierre, SD 57501-2291

605-773-6317 or toll free at 1-800-696-9476 (in-state only)

SOUTH DAKOTA CRIME VICTIMS' COMPENSATION PROGRAM
South Dakota Department of Social Services, Division of Adult Services & Aging, Victims' Services Program
700 Governors Drive
Pierre, S.D. 57501-2291
(605) 773-6317 or 1-800-696-9476 (in state only)
Web address: http://dss.sd.gov/victimservices/cvc/index.asp
Email address: VictimsServices@state.sd.us

Eligibility: You may be eligible for compensation if the following requirements are met.

- You or a family member has suffered personal injury or the threat of personal injury as a result of: a violent crime, trying to stop a person committing a crime, trying to help a law enforcement officer, trying to help a victim of a crime or witnessing a violent crime.
- The incident was reported to law enforcement within (5) days of when it could reasonably have been reported, and the victim reasonably cooperated with the investigation and prosecution of the incident. If the crime was not reported within 5 days of the date that it occurred or if the victim did not reasonably cooperate, please submit a letter explaining the reason for the delay in reporting or decision not to cooperate.
- An application must be filed within (1) year of the incident, except for good cause. If you are filing past 12 months, please submit a letter stating the reason for the delay.
- The victim did not cause or contribute to the injury or death and was not committing a crime.
- The compensation will not unjustly benefit the offender or an accomplice.

Who can file an application:

An innocent victim who has suffered personal injury or the threat of personal injury, a family member of a deceased victim, a person authorized to act on behalf of a victim or dependent and/or family members of victims under limited circumstances.

Application Instructions

1. Please type or print clearly.
2. Please complete only the sections that you, or the victim you are assisting, want compensation for.
3. If sufficient space is not provided on this form, use additional sheets as necessary.
4. If you need any help in completing the application, call (605) 773 6317 or 1 800 696 9476 (in state only).
5. Attach all medical, hospital and/or funeral bills that you have received and that apply to this request for compensation or provide the names, addresses and telephone numbers for all providers.
6. The application must be signed by the applicant, or an authorized representative. If the victim is under 18, an authorized representative must sign. In the event of death or incapacitation, an authorized representative must sign for a victim over 18 years of age. Authorized representatives signing this form must complete section III.
7. In the event of death of the victim, be sure to fill out **SECTION X - Death as a result of a crime**. The maximum amount that may be awarded for funeral and burial expenses is $8,000.00 including up to $2,000.00 for a headstone and up to $1,000.00 for miscellaneous expenses.
8. The maximum amount that may be awarded for each victim of a crime is $15,000.00.
9. Victim's Services must be notified of any change in the applicant's address or telephone number.
10. If you do not know the answer to a question write "unknown".
11. The application must contain a brief description of the crime (see Section V).

You must fill out every applicable section completely to have your claim processed.

SOUTH DAKOTA

CRIME VICTIMS'COMPENSATION

APPLICATION

RETURN TO:

Department of Social Services
Division of Adult Services and Aging
Crime Victims' Compensation Program
700 Governors Drive
Pierre SD 57501-2291

DO NOT WRITE IN THIS SPACE

CLAIM# _____

DATE RECEIVED _____

PLEASE READ INSTRUCTIONS BEFORE BEGINNING

SECTION I. Victim Information

Victim's Name:_____ Soc. Sec. No._____

Date of Birth:____/____/_____ Age:_____ ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widow

Mailing Address:_____
Street City State Zip Code County

Home Phone: (____)_____ Work Phone: (____)_____

Cell Phone: (____)_____ Email Address: _____

SECTION II. Additional Information

Information required by the Department of Justice

1a. Race of victim: ____Caucasian ____Hispanic ____Black ____American Indian or Alaskan Native

____ Asian or Pacific Islander ____Other

1b. National Origin of victim: if other than USA: _____

2. Did the victim have a disability before this crime occurred? ☐Yes ☐No Explain:_____
_____

3. Is the victim disabled as a result of this crime? ☐Yes ☐No Explain:_____

_____

4. Is the victim a South Dakota resident? ☐Yes ☐No ☐Unknown

5. Was the crime a federal offense? ☐Yes ☐No ☐Unknown

SECTION III. Claimant Information

(Complete Section III only if someone other than the victim is filing the claim.)

If you have been appointed legal guardian of the victim, please attach a copy of the guardianship document.

Claimant Name:_____ Relationship to Victim:_____

Date of Birth:____/____/____ Social Security Number_____

Mailing Address:_____
Street City State Zip Code

Home Phone: (____)_____ Work Phone: (____)_____

Cell Phone: (____)_____ Email Address: _____

SECTION IV. I learned about this program from (check one):

☐ Prosecuting Attorney ☐ Hospital, Doctor, etc. ☐ Brochure/Poster ☐ News Media
☐ Non-profit Service Agent ☐ Family Violence Shelter ☐ Relative/Friend ☐ DSS
☐ Counselor/Therapist ☐ Law Enforcement ☐ Victim Witness Program ☐ Internet
☐ Other_____

SECTION V. Crime Information

(Note: The crime must have occurred on or after July 1, 1992)

Location of Crime:_____
Street City State Zip Code County

Date of Crime:____/____/____ Date Reported:____/____/____

Law Enforcement Agency crime was reported to: _____

Law enforcement case#:_____ Who committed the crime? _____

☐ Yes ☐ No ☐ Unknown Victim knew the offender? If yes, in what way? _____

☐ Yes ☐ No ☐ Unknown Victim was related to the offender? If yes, how?_____

☐ Yes ☐ No ☐ Unknown Was victim living in same house as the offender? If yes, is victim still living in the same house as the offender? ☐ Yes ☐ No ☐ Unknown

☐ Yes ☐ No ☐ Unknown Has the offender been charged in court?

☐ Yes ☐ No ☐ Unknown Was the offender ordered to pay restitution? If yes, complete the following:

Amount ordered:_____ Amount received:_____

☐ Yes ☐ No ☐ Unknown Is the victim or claimant considering a civil action? If yes, complete the following:

Attorney:_____ Telephone: (____) _____

Address:_____
Street City State Zip Code

Briefly describe the crime and the injuries that you incurred. Attach additional sheets if necessary:

_____

_____

_____

_____

SECTION VI. Lost Wages as a result of the Crime

Are you, or the victim that you are assisting, requesting compensation for lost wages? ☐ Yes ☐ No
(Note: Compensation for lost wages is paid at the Federal minimum wage.)

Was the victim employed at the time of the crime? ☐ Yes ☐ No If yes, complete the following:
☐ Part Time ☐ Full Time **If Self Employed, include copy of most recent Federal Income Tax return.**

Please provide employer information for all employers during the 6 months prior to the crime.

Employer:_____ Contact Person:_____

Address:_____
Street City State Zip Code

Telephone: (____) _____

Employer:_____ Contact Person:_____

Address:_____
Street City State Zip Code

Telephone: (____) _____

Section VI: Lost Wages as a result of the Crime……continued

Did the victim miss any time from work as a result of the crime? ☐ Yes ☐ No

If yes, please complete the following: _____weeks _____days, from (dates) _____ to _____

Note: If over 40 hours, a physician disability statement is required.

Has the victim returned to work? ☐ Yes ☐ No If yes, when?_____

Did the victim's wage continue while off work? ☐ Yes ☐ No If yes, complete the following:

Source (Check)	Amount per week	From (date) to (date)
___ Worker's Comp		
___ Unemployment Comp		
___ Health Plan		
___ Vacation or Sick Leave		
___ Disability Pay		
___ Other, Specify		

Check if you, or the victim you are assisting, had or currently have income from the following:

Income source	At the time of the crime	Currently
Social Security	☐ Yes ☐ No	☐ Yes ☐ No
Social Security Disability	☐ Yes ☐ No	☐ Yes ☐ No
General Assistance	☐ Yes ☐ No	☐ Yes ☐ No
Food Stamps	☐ Yes ☐ No	☐ Yes ☐ No
T.A.N.F.	☐ Yes ☐ No	☐ Yes ☐ No
Other, Specify:_____	☐ Yes ☐ No	☐ Yes ☐ No

If you, or the victim you are assisting, was not employed or receiving assistance at the time of injury, please list the source of income:_____

SECTION VII. Insurance or Benefits From Other Sources

Did the victim have coverage or was entitled to benefits from any of the following at the time the crime occurred?

Source	Yes	No	Identify contact person and Phone Number, Address and Policy/Case Number
Health Insurance	____	____	_____
Auto Insurance	____	____	_____
Life Insurance	____	____	_____
Disability Insurance	____	____	_____
Public Assistance	____	____	_____
Medicaid	____	____	_____
Medicare	____	____	_____
Social Security	____	____	_____
Worker's Compensation	____	____	_____
Veterans' Administration	____	____	_____
Indian Health Service	____	____	_____
Other	____	____	_____
	____	____	_____

SECTION VIII. Medical Bills as a result of the Crime

Name of Provider	Amount of Bill to Date	Amount Paid by Victim/Claimant	Amount Paid By Others	Balance
Hospital				
Doctor				
Home Health				
Counseling				
Dentist				
Optician				
Ambulance				
Others				

Do you anticipate receiving more medical bills? ☐ Yes ☐ No If yes, please describe:_____
Please attach copies of all bills, receipts, and insurance benefits statements that you have received.

SECTION IX. Other Expenses or Losses as a result of the Crime

(Attach receipts or estimates.)

☐ **Clothing** taken as evidence (Include receipts if available.) List clothing items: _____
☐ **Transportation (Outside of city limits)** Check all reasons for transportation that apply.
☐ Medical Treatment / Exam ☐ Mental Health ☐ Court proceedings
☐ Law Enforcement meeting ☐ Funeral
☐ **Lodging** Check all reasons for lodging that apply.
☐ Medical Treatment / Exam ☐ Mental Health ☐ Court proceedings
☐ Law Enforcement meeting ☐ Funeral
☐ **Child Care** Number of days childcare services were needed: _____
Service Provider:_____
Reason childcare was required: ☐ Physical or Emotional impairment ☐ Attend Court proceedings
☐ Law Enforcement meeting ☐ Medical appointment
Amount paid by Victim/Claimant:$_____ by others:$_____Balance Due:$_____
☐ **Security Devices** (includes caller ID box, home security devices)
Amount paid by Victim/Claimant:$_____ by others:$_____Balance Due:$_____
☐ **Other** _____(specify)

SECTION X. Death as a result of the Crime

(Note: If the victim died as a result of the crime, please complete the following.)

Date of Death:_____ **(Attach copy of Certificate of Death.)**

Did the victim have life insurance? ☐ Yes ☐ No If yes, complete the following:

Name and Address of Company :_____

Beneficiary: _____ Amount:$_____ Policy Number: _____

Homicide scene expenses

Name and Address of Company: _____ Amount:$_____

Amount paid by Victim/Claimant:$_____ by others:$_____ Balance Due:$_____

SECTION X: Death as a result of the Crime……continued

Funeral and Burial Expenses

Did the victim have burial insurance? ☐ Yes ☐ No If yes, complete the following:

Name and Address of Company: Amount Policy Number

_____ $_____ #_____

Name of Funeral Home:_____ Address:_____

Amount of funeral and burial expenses: $_____ Have expenses been paid? ☐ Yes ☐ No

If yes, by whom? Name:_____ Address:_____

Telephone: (____)_____ (Attach copies of bills; if paid, attach proof of payment.)

Name of Monument Company:_____ Address:_____

Amount for Headstone: $_____ Have expenses been paid? ☐ Yes ☐ No

If yes, by whom? Name:_____ Address:_____

Telephone: (____)_____ (Attach copies of bills; if paid, attach proof of payment.)

Memorial and Miscellaneous Expenses: $_____ Have expenses been paid? ☐ Yes ☐ No

If yes, by whom? Name:_____ Address:_____

Telephone: (____)_____ (Attach copies of bills; if paid, attach proof of payment.)

Beneficiary / Dependent Information

At the time of death, did the victim contribute financial support for any dependent(s)? ☐ Yes ☐ No
If yes, amount/month $_____
(Attach documentation of amount such as a paystub, tax return or name and address of employer.)

Will the dependent(s) receive benefits from the following? (Provide amount for each benefit type.)

☐ Yes ☐ No	Social Security	$_____	☐ Yes ☐ No	Worker's Compensation	$_____
☐ Yes ☐ No	Life Insurance	$_____	☐ Yes ☐ No	Public Assistance	$_____
☐ Yes ☐ No	Tribal Fund	$_____	☐ Yes ☐ No	Other	$_____

Please provide the following information about the victim's dependent(s).

1._____

Name: (Last) (First) (Middle) Sex Date of Birth

_____

Address: Street City State Zip Relationship to Victim

2._____

Name: (Last) (First) (Middle) Sex Date of Birth

_____

Address: Street City State Zip Relationship to Victim

(attach additional sheets if more than 2)

Please complete the following attached documents:

1. Declaration and Authorization (1 page) – Required
2. Authorization for the Use and Disclosure Of Protected Health Information (3 pages) – Required
3. W-9 (1 page) - Required only if out of pocket expenses requested on application.

You will receive a letter verifying receipt of your application within two weeks. If you have any questions regarding the status of your claim, please feel free to call **1-800-696-9476** or **605-773-6317**.

Please return to:
Department of Social Services
Division of Adult Services and Aging
Crime Victims' Compensation Program
700 Governors Drive
Pierre SD 57501

DECLARATION AND AUTHORIZATION

I declare and affirm under the penalties of perjury that the application has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

If I am awarded compensation, I promise to repay the State of South Dakota Crime Victims' Compensation Program for any payments received from the person who committed this crime, whether from restitution or civil action, or from any insurance company, or any other governmental or private agency, which payments are for any injury or loss included in my claim. Further, I promise to give my written notice to the Crime Victims' Compensation Program if I pursue a claim or demand, or if I file a lawsuit for the damages sustained.

I authorize and request any person having information necessary to the administration of my claim, including all records related to this claim concerning me, to release that information to the Crime Victims' Compensation Program, South Dakota Department of Social Services. This release includes, but is not limited to law enforcement agencies, past and present employers, and any private company or governmental agency which is providing, or may provide, medical or monetary benefits. I agree and certify that no person shall incur any legal liability to me by releasing any information pursuant to this authorization. A photocopy of this authorization shall have the same effect as the original.

Signature of Victim: _____

Authorized Representative: _____

Relationship to Victim: _____

Print Name(s):_____

Dated this _____ day of _____, 20 _____

Authorization for the Use or Disclosure
Of Protected Health Information

As required by the Health Insurance Portability and Accountability Act of 1996, the South Dakota Department of Social Services may not use or disclose your health information, except as provided in our Notice of Privacy Practices, without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and return it to the Department.

(Victim Information) I hereby give my consent to release the information described below concerning:

Patient/Participant Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Phone #: _____ Recipient ID #: _____

Please complete the below information for each provider. If there are more than six providers, please contact our office for additional release forms, at 605-773-6317. Please fill in dates of service at bottom of next page.

(Provider Information)The specified information is available from the following individual or entity:

Name: _____ Organization: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____ Email: _____

(Provider Information)The specified information is available from the following individual or entity:

Name: _____ Organization: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____ Email: _____

(Provider Information)The specified information is available from the following individual or entity:

Name: _____ Organization: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____ Email: _____

(Provider Information)The specified information is available from the following individual or entity:

Name: _____ Organization: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____ Email: _____

(Provider Information)The specified information is available from the following individual or entity:

Name: _____ Organization: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____ Email: _____

(Provider Information)The specified information is available from the following individual or entity:

Name: _____ Organization: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Fax #: _____ Email: _____

The specified information is to be released to the following individual or entity:

Department of Social Services
Division of Adult Services and Aging
Crime Victims' Compensation Program
700 Governors Drive
Pierre SD 57501-2291

Specific information requested: medical records, itemized statements, copies of EOB's, ER reports and completed expense verification form.

Specific dates for the information requested: _____

Purpose of the disclosure: Processing of Crime Victims' Compensation Claim.

I understand the information received may include information relating to drug and/or alcohol abuse or physical/sexual abuse. The South Dakota Department of Social Services, its employees, officers, and medical providers are hereby released from any legal responsibility or liability for release of the above information to the extent indicated and authorized herein.

As stated in the Department's Notice of Privacy Policies, this consent form may be cancelled at any time except to the extent the staff have taken action upon it. If not cancelled, this consent to release information will terminate in **one year** or upon the following specified date:_____. I understand that this authorization may be revoked at any time, as long as I do so in writing.

I understand if this information is released to a third party, the information may be released by the person or entity that receives the information and may no longer be protected by federal or other applicable privacy regulations. Exception -- drug and/or alcohol treatment information, HIV testing information, and mental health treatment information may not be redisclosed without my specific consent.

I understand that I am under no obligation to sign this authorization. If the information requested is necessary to determine if I am eligible to enroll in benefits available through the South Dakota Department of Social Services or to determine if another medical program can pay for my health care, I understand that if I choose not to authorize the disclosure and use of this information, I may not be able to show that I qualify. If the South Dakota Department of Social Services has been asked to allow or pay for a health care service on my behalf (such as a test or evaluation) for the purpose of providing the results of those services to someone else, I understand that if I choose not to authorize the disclosure of that information to the other person, the Department of Social Services may not allow the service or the payment for the services provided on my behalf.

_____ _____

Signature of participant/patient, parent, guardian, or authorized representative giving consent

Date

_____

Print Name

Relationship to Participant/Patient

_____

Witness Signature

Print Witness Name

Relationship to Participant/Patient

_____

Telephone number of the participant/patient, parent, guardian, or authorized representative for verification of the request for information

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REVOCATION OF AUTHORIZATION

(Only sign if you wish to cancel your authorization.)

I hereby cancel this request to release information effective immediately:

_____

Signature

Date

Form **W-9**
(Rev. August 2013)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:
☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____

☐ Other (see instructions) ▶

Exemptions (see instructions):
Exempt payee code (if any) _____
Exemption from FATCA reporting code (if any) _____

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
☐☐☐ - ☐☐ - ☐☐☐☐

Employer identification number
☐☐ - ☐☐☐☐☐☐☐

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below), and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here | **Signature of U.S. person ▶** | **Date ▶**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. The IRS has created a page on IRS.gov for information about Form W-9, at *www.irs.gov/w9*. Information about any future developments affecting Form W-9 (such as legislation enacted after we release it) will be posted on that page.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, payments made to you in settlement of payment card and third party network transactions, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct.

Note. If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.